Substance Misuse Management in General Practice (SMMGP)

Towards a Primary Care Network

February 2001 Newsletter No.19

Funding and Planning Drive to Support Shared Care and Drug Misuse Services in 2001

Health Authority Chief Executives were posted a '***CLA Notification – Additional Funding for Drug Misuse Services 2000/01***' on 6 December 2000 from the Department of Health. This document outlines an ambitious programme of work to support the 10-year strategy to tackle drug misuse and is supported by a £25 million package of additional, non-recurrent Health Authority funding which must be spent in this current financial year. Some of this is to be locally managed with funding direct to Health Authorities. Other work will be regionally or centrally managed. The aims include:

Capacity building - There is new funding of £6.9 million towards capacity building, with £5.4 million of this to support Health Authorities increase availability of treatment services, in their broadest definition. The funding is intended to access 15% more problem drug misusers (excluding those from the criminal justice system) into drug treatment services by March 2001. The additional funding is intended to help meet this target through measures such as; bringing forward resourced expansion plans; additional staff time; extra short term treatment slots; efficiency measures; capital investments in premises. An **enhanced primary care involvement** in treatment services is being recommended through the use of the funding flexibility provided by HSG (96) 31, and Local Development Schemes for 'extra' GMS GPs **[See page 6 of this newsletter]**. £1.5 million funding is also available for Health Authorities with prisons to implement new guidance on treatments, in particular detoxification and the drugs element of Health Needs Assessments.

Expanding shared care and reduction of drug related deaths - Funding of £5.445 million has been allocated to help Health Authorities implement recommendations from the Clinical Guidelines in order to help reduce drug related deaths and co-ordinate the strategic development of shared care. Each Health Authority has been given £20,000 to help set up a **shared care monitoring group (SCMG)** or to support the operational development of existing groups. £35,000 has also been allocated for the development of schemes to reduce leakage of prescription drugs to be led by SCMG. Funding is also available to reduce injecting.

Training – As reported in our last newsletter, there is also significant funding for training. Funding for primary care generalist training is to be managed through the postgraduate education system. Intermediate level practitioner training (specialised generalists), and training for commissioning and planning leads for primary care will be delivered via Royal College of General Practitioner certificate and diploma [**See SMMGP 18 on www.smmgp.demon.co.uk]**. The RCGP is currently appointing its Expert Advisory Group members, Chair and Project Manager in order to deliver this training later in the year. Funding has also been made available for regionally managed ***dual diagnosis training.***

Other uses for the funding include ***Recruitment of Drug Workers, the*** next stage of the Government's Recruitment Campaign (centrally managed with funding direct to Drug Action Teams); and an increase in ***prevention*** services including assessment of prevention and treatment needs for minority ethnic groups.

Shared Care Monitoring Groups (SCMG)

Funding for Implementation of SCMG, follows their recommendation in the 'Clinical Guidelines'. The SCMG should act as a strategic lead in the development and co-ordination of shared care. This includes the facilitation of new contractual and operational arrangements where historical arrangements are not adequate for meeting the needs of shared care. SCMG as part of the DAT structure, could be effective in responding to the full range of quality issues that go with prescribing treatments, and provide forums for the resolution of local differences on clinical practice. Key stakeholders include the Drug Action Team; Lead drug and alcohol commissioners; Local GPs; Local Medical Committee; Local training providers; Pharmacists; Primary Care Groups; Prison health care workers; Public Health; Regional Drug Lead; Treatment providers and treatment consumer groups.

Continued - See DOH SCMG Responsibilities p.2

6th National Conference

MANAGING DRUG USERS IN GENERAL PRACTICE

Government Drugs Policy and Training

The New Agenda for Primary Care

Hilton Hotel Glasgow 10th-11th May 2001

This conference organised by the Primary Care Network has been running since 1995. It is designed both for those with little or no experience in managing drug users and those more skilled in this area. 2001 themes include: GP training in England and Scotland; role of specialised generalists; drug related deaths; getting started in primary care. Workshops include: pregnancy; buprenorphine; cannabis; the National Treatment Agency.

Contact the RCGP Courses Unit on 020 7823 9703, courses@rcgp.org.uk or www.rcgp.org.uk

DOH suggested responsibilities for Shared Care Monitoring Groups *(Cont. from p.1)*

1. Introduce shared care into the locality as defined by the Clinical Guidelines and EL (95) 114).
2. Establish local guidelines for shared care.
3. Establish links with local training schemes including, where appropriate, ensuring the training is congruent with the National guidelines for the specialised-generalist practitioners.
4. Act as the advisory group for the issuing of Home Office prescribing licenses to general practitioners.
5. Review existing local services, in particular, to meet the needs of the new primary care led NHS.
6. Review existing contracts for local drug services where they relate to primary care.
7. Establish links with local Public Health departments and, possibly, service as the link, through Regional (or H A) clinical drug leads, between Central and Regional Officers and HO Drugs Inspectorate.
8. Ensure mechanisms to stop leakage of diverted drugs – develop guidance on schemes to reduce leakage, e.g. supervised ingestion schemes.
9. Monitor the performance indicators listed within the guidelines relating to shared care, such as percentage of participating GPs with clear guidance for shared care, percentage of GPs prepared to take or undertake shared care responsibilities and percentage of specialist drug service patient's cared for in general practice. Indicative targets within the drug strategy sets targets of 20% of GP involvement.

SCMG Advice: Access specific SCMG advice on the SMMGP web site: www.smmgp.demon.co.uk or contact Jim Barnard on 0161 905 1544, Jean Claude Barjolin on 01756 709708 or Richard Cyster (RSDC) on 0113 2448277

How do Services Measure Up to Standards Set in the Clinical Guidelines?

The need to re-engage GPs in providing treatment was first identified by the ACMD in 1982. This seemed to introduce the need for guidelines in order to ensure that GPs were held in check. Three sets of 'orange guidelines' have now been produced setting in place increasingly structured protocols. The 'British System', which allowed considerable flexibility in matching treatments to patient need, is being challenged.

The most recent 'Guidelines' (DoH 1999) is the longest, most exhaustive and most prescriptive in its recommendations. It also claims a legal status not envisaged by its predecessors. Briefly that in a court of law they could be held up as a standard of good practice, although not legally binding. They also have the status of being explicitly part of the Government's treatment strategy as outlined in 'Tackling Drugs Together to build a better Britain'.

So given that they are the most formal and high status guidelines that have been produced so far, what has been their impact. There are several areas in which the 'Guidelines' outlined practice that many specialist centres did not comply with at the time. One year after publication we undertook a survey of 178 specialist treatment agencies throughout England and Wales. 99 responded of which 93 were valid responses. The results were informative.

In terms of **supervised consumption**, it was available at 63 of the sites, of which 23 started all their clients on supervised consumption. 17 sites delivered supervised consumption for at least 3 months as recommended in the guidelines, but this was not always for all clients. In terms of **initial dose induction**, 14 services saw people at least daily for the first few days, 13 two or three times a week and 65 did so weekly or fortnightly.

In terms of **shared care**, in 6 services all prescriptions were written by local GPs. In 28 services, all prescriptions were written by 'in house' prescribers. In 59 of the services, the prescriptions for people seen by the service were written by a mixture of GPs and in house prescribers. 72 areas said they had existing shared protocols in place, 21 did not. 22 areas said they had **training available for GPs** as outlined in the 'Guidelines' but said that very few GPs received it.

Slightly worryingly, although 90 services said they did '**thorough initial assessments** and conducted urinalysis prior to issuing a prescription, two services said they did this only sometimes. Also only 15 services always carried out a thorough physical examination prior to prescribing, with 25 services never doing this.

Overall 34 services said that they presently **complied with the 'Guidelines'**, another 26 aimed to do so in the future and 33 aimed to be partially compliant. However none of services actually measured up to the standards set in the 'Guidelines' when their responses were analysed.

Other interesting **prescribing** information emerged from the survey. 25 services prescribed diamorphine, and 31 dexamphetamine. 47 prescribed injectable methadone, slightly more than the 46 that prescribed buprenorphine (Subutex). It seems that there is a broader range of prescribing options in use than often imagined.

Topics not covered in the survey included the setting up of **shared care monitoring groups**. This seems to have been very rare. Also the prescription of methadone tablets, outlawed in the guidelines, is still probably quite common. It would be useful to know whether services are prescribing less than 30 mg of benzodiazepines (64 of the services prescribed benzodiazepines). Finally, do all teams or GPs use an assessment tool to assess the severity of dependence? The recommended ones were the Addiction Severity Index, The Opiate Treatment Index and the Maudsley Addiction Profile.

In conclusion there does seem to be a shift in practice as a result of the 'Guidelines'. Far more services are offering supervised consumption than would have been the case before their publication. This is also true of the dose induction procedures. On the other hand there does seem to be a considerable gap between services perceptions of complying with the 'Guidelines' and the reality. It is also interesting that over a third of services did not intend to comply fully with the 'Guidelines'.

Research by Dr Ian Telfer and Jim Barnard
Ian Telfer - Consultant in Substance Misuse for West Pennine Tameside General Hospital, Fountain Street, Ashton under Lyne, OL6 9RW, Tel: 0161 331 5094.

Working with 'Dual Diagnosis' in a Substance Misuse Team

The Junction Specialist Substance Misuse Agency in Brent established its Dual Diagnosis Service nearly three years ago. Initially the service faced all the problems inherent in such an undertaking, and which will be familiar to many agencies. Issues such as: which team (substance misuse or mental health) should provide the main keyworker; the 'chicken and egg' scenario i.e. Is the clients' drug use the primary or secondary issue; are the effects of drug use mimicking mental health symptoms; and which issue to tackle first. All of the above issues have to be considered when setting up a new service.

There is some evidence that clients in this group are notoriously difficult to engage in services and are often poor compliers with medication. Certain ethnic minorities are over-represented in this client group and such clients are also often over-represented within the criminal justice system.

One response to the above problems has been to locate the treatment approach in a medical model of substance misuse (i.e. disease model), which may be applied with abstinence as the only legitimate goal. Other approaches, such as harm reduction and collaborative user-focused models are often not considered, assuming that clients do not have the cognitive skills to make informed decisions regarding their substance use. The 'one size fits all' approach often identifies the client group as homogenous rather than heterogeneous, and this can create new labels and new stigmas, only serving professionals rather than clients. Treatment is often sequential rather than concurrent, which can result in clients being passed backwards and forwards between services. However, research indicates that a concurrent approach, whereby mental health substance misuse treatment is delivered in a broad context, including daily living skills, anxiety management and relapse prevention under one roof, can be more effective.

The Junction Project works in close partnership with Arlington Care who are commissioned to provide alcohol treatment services. We have put together key features from successful models both here and in the US. This has resulted in a client-focused collaborative model, based on a pragmatic harm reduction framework. This work has been delivered through a system of satellite services set up throughout the Trust. This includes acute wards, mental health day centres and primary care settings. At each location we have established a liaison or named worker in order to simplify the referral process.

We have developed a training programme for all staff teams, looking at multi-modal treatment approaches to substance misuse and mental health. The purpose of this training programme is to raise the skill base through all grades of staff, so that skills which are currently perceived as specialist, become generic.

The Dual Diagnosis team still carry a small dedicated case-load, but their role will evolve into providing clinical supervision and support for both mental health and substance misuse teams. As our model uses concurrent treatment and a longitudinal approach, it provides an opportunity to develop joint partnerships with all the agencies involved, both voluntary and statutory.

Our experience in Brent has shown that to be effective these policies and protocols have to be developed at a strategic level and everyone, from consultant psychiatrists to the local police team, has to be on board. In addition to this, outcomes have to be realistic and the programme has to be one which clients want to access.

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Next Newsletter – GP Payments

Why pay? How much? What payment structure?
What services are GPs being reimbursed for?
What funding arrangements can be used?
Examples from a variety of UK schemes
UK consistency or locally negotiated rates?

Is dual diagnosis a red herring?

Editorial comment

Dual diagnosis or co-morbidity has attracted a lot of attention over recent years. One perspective is that dual diagnosis has been around for a long time, but now we are giving it a label. On the same theme, many so called complex clients in drug services and primary care may not be 'genuine' dual diagnosis cases. Often they represent people with multiple social and medical problems, history of depression and cases of personality disorder. In this sense the labelling of many clients as dual diagnosis has become a common misnomer for people with multiple needs of which substance misuse plays a part.

However, cases of homicide and suicide, particularly cases involving people with psychotic disorders, such as schizophrenia, have highlighted where people fall through the gaps of mental health and substance misuse services. People with diagnosed psychosis should be clearly managed by psychiatrists. But what we also know is that probably the majority of such diagnoses do also use drugs and alcohol. Alcohol and drug misuse amongst people with mental health disorders must be considered as usual rather than exceptional. Psychiatry and substance misuse services cannot work exclusively with such clients. Some form of integrated approach is necessary. However, there is little evidence about effective treatment and none from the UK. Evidence from the US suggests that integrated teams working in shared premises are the best approach. But this evidence has not been generated or analysed in the UK context.

'Dual diagnosis' is still high on the agenda but we have often not distinguished what we are actually talking about. In many cases 'dual diagnosis' serves as a metaphor for clients we are not sure what to do with within a service or in terms of joint working between services. We should maybe use this label more sparingly.

Co-morbidity Standards are currently being developed by the Substance Misuse Advisory Service (SMAS) / Health Advisory Service (HAS). They are to be used for the HAS reviews of adult mental health services (they are not aimed at drug services). An additional project being conducted by SMAS/ HAS involves the update of the HAS 1996 document on drug use and young people. The project is funded by the Drug Prevention Advisory Service and led by Dr Eilish Gilvarry a consultant psychiatrist. **Contact SMAS, 46-48 Grosvenor Gardens, SW1W OEB, London 020 78819255/64**

GP Specialist and GP Liaison Team in a Specialist Drug Service

The Wirral peninsula, like other urbanised areas in the U.K., experienced a huge upsurge in heroin use in the early 1980's, resulting in an estimated 5,000 heroin users on the Wirral alone by 1984, 1.5% of the total population. Treatment services at the time were not able to respond to this problem. In August 1988 the Wirral HIV/AIDS Prevention Unit was set up at St. Catherine's Community Hospital in Birkenhead. Dr. Stefan Janikiewicz was appointed as Clinical Director; a local GP, already prescribing to drug users from his own surgery.

The treatment provided at the Drug Unit increased stability and improved the health for a substantial proportion of its clients. It became clear that this group did not need the intensive input from a Specialist Drug Unit and would be far better placed back with their GP to continue their treatment. This enabled more chaotic clients to be brought into treatment at the clinic. Some GPs were happy enough to do this but still requested a degree of support.

In 1993 the unit began to work in a far more formalised way with local GPs. Although GPs had treated drug users prior to the unit's opening it was in a piecemeal and unsupported way, with no overall guidelines and protocols. A new GP Liaison Team was set up and GPs were encouraged to join the scheme. The Wirral Drug Service was one of the first UK Drug Units to formalise this idea into a working set of guidelines and protocols.

We currently monitor 560 clients through 70 GP's at 28 individual practices across the Wirral. The Liaison service has learnt to be flexible and pragmatic when working with GPs (essential!) and so we operate monthly clinics, shared care and community support schemes, all responding to the local characteristics of practices.

A worker is attached to a specific surgery and acts as the focal point for all patients registered at that practice with drug related problems. Newly registered patients are assessed and placed accordingly. Patients' care can be transferred back to the GP from the Drug Service in a planned and co-ordinated way. Patients are only transferred to the care of their GP when their drug use has been stabilised and other aspects of their behaviour and lifestyle have improved. A set of prescribing rules has been agreed with GPs that helps to ensure the surgery manages stable patients.

Prescribing Rules

- Oral methadone, maximum daily dose 70mgs, is generally the rule.
- No benzodiazepines prescribing, unless as an agreed reduction plan.
- No prescribing of injectables, unless as an agreed plan to change to oral medication.
- No prescription initiated until patient assessed by the GP Liaison worker.
- No methadone tablets, unless as an agreed time limited reduction.
- Clients who become unmanageable are transferred back to the Drug Unit.
- Clients who are ill through drug misuse, e.g. Hep C, are usually cared for at the Drug Unit.
- Pregnant drug users are normally cared for at the Drug Unit, although many GP's are now happy to continue with their care at the surgery.

The General Practitioner Clinic - The standard clinic operates on a monthly basis, with the client, GP and GP Liaison Worker attending at the surgery at the agreed clinic times. We have learned, however, to be flexible and GPs who are reluctant to hold clinics in their surgeries for historical or pragmatic reasons can still be accommodated within the scheme.

Shared care systems of working have also been in place for a number of years. Clients are seen at home and reviewed regularly by the GP in ordinary surgery time. In both systems, the GP worker generates prescriptions, applies for handwriting exemptions etc, and generally organises the clinics and client treatment plans.

Funding & PCGs - GP budgets are top sliced to provide funding for drug treatment. £133K provides the budget to run the scheme. £80k provides staffing and £50k is recycled back to GP's in the scheme in the form of payments for clients seen. The rate at the moment is £93 per annum per patient. The Wirral area is divided into 3 PCGs, with plans in progress to move towards 2 PCTs. We have recently attracted funding from one of these PCGs to increase our service capacity and reduce our waiting list for clients from their catchment area. This kind of identified need and subsequent purchasing by PCGs may well be a way forward for us as we intend to expand further this year and may well seek additional funding in this way.

Overall Wirral Drug Service now treats approximately 1,300 people in varying stages of their drug use, we have been operating for almost ten years and have now grown into the largest drug service in the United Kingdom and one of the largest in Europe, employing over 40 staff. We feel it is unique in the varied services offered to drug users on the Wirral.

Mark Harris Clinical Co-ordinator
GP Liaison Team, Wirral Drug Service, St Catherine's Hospital, Derby Road, Tranmere, Merseyside CH42 0LQ: 0151 604 7303 Web-site www.wirraldrugservice.org.uk

Discussion - Maintenance Prescribing Dose

The Clinical Guidelines recommend between 60-120mgs methadone daily for effective maintenance. For stable patients in general practice/shared care, should there be a upper dose e.g. 70mgs set below the upper level recommended in the Clinical Guidelines. Or should GPs be supported in using the full maintenance range recommended. Dialogue welcome on this point. Editor

Evolution of PCG 'Specialist Clinics' - A Bridge to Shared Care?

Should GPs manage their own patients' drug use in their own surgery?

Discussion: There is increasing interest in PCG led schemes which have a specialised generalist clinic providing a type of referral or deputising service for other GP patients' substance misuse management. Should we be encouraging GPs to manage their own patients once stable, with training and support? Or is this a useful GP led service tier, which can allow those GPs who do not feel confident or interested to delegate treatment to another GP. Does it allow for the normalisation of care and 'shared care' – do these matter? Is this a useful starting point or bridge to broader primary care involvement? Can these clinics provide flexible and cost effective primary care led, and PCG accountable, middle tier 'specialist services'? How does this fit with the more traditional Trust and psychiatry led DDU/CDT model? Dialogue welcome. Editor

Primary Care Group Locality Substance Misuse and Prescribing Clinics Through Local Development Scheme Funding

Our Primary Care Group (PCG) Substance Misuse Treatment and Prescribing Clinics are a community service available to all GPs within a PCG locality. The clinics are run as a partnership between the specially trained GP provider and specialist Drug Workers at a Turning Point agency. Being based here means that all patients having treatment for substance misuse are seen outside of their GP surgery. As specialised GPs (Three of us at present, including myself as lead GP) these services are provided on behalf of our GP colleagues. Patients are expected to consult their own GP for all other general medical problems.

How did our service evolve? In 1995 the Wakefield Local Medical Committee following consultation with its members concluded that GPs should not prescribe substitute opiates for detoxification without adequate training and experience. This was in direct response to the sharp and surprising rise in opiate addiction. The PCG Service was a direct response to the concerns of local GPs and the obvious need to provide a high quality primary care service to drug users which addressed their general health needs and problems of addiction. The key development was a move towards the GP engaging in 'shared care' working with other agencies, and commitment by the Health Authority and the PCGs to invest in this model of care. In addition to investment in the capacity, premises and workforce of the other partner agency, the localities and Health Authority supported and funded the necessary GP specialist training.

The core services of the PCG Prescribing Clinics - All patients within the PCG have access to a specially trained GP who always works in partnership with a specialist Drug Worker who is the patient's key worker. There is a detailed assessment process prior to acceptance onto a patient centred treatment programme. The programme currently includes counselling, prescribing of substitute opiates where appropriate, auricular acupuncture and regular on site training. We have local policies and protocols governing all aspects of the service. The service has developed with an integral role for the community pharmacist including a number of sites where supervised dispensing of methadone and the newer substitute opiate, buprenorphine (Subutex), can take place. Pharmacists are informed by fax/telephone of all prescriptions required for dispensing. Similarly, all GP Practices are faxed after each clinic with information regarding the prescribing of all their own patients. They are also updated monthly regarding the waiting list for accessing a clinic place. A service aim is to keep waiting lists for treatment below four weeks and have a well publicised procedure for dealing with urgent referrals.

What has been the impact of a PCG based Substance Misuse Service? - The centralisation of clinical services to drug misusers within a locality has released valuable GP time for the benefit of patients at the practice. It has also enabled prescribing costs to be more easily monitored. The service is involved in regular audit activity and issues of quality can now be addressed through the clinical governance lead.

Tips on setting up a Primary Care Group Substance Misuse Service - Firstly gauge the support of the Localities' GPs and perform a Health Needs Assessment on the local drug abusing population. Your Health Authority should provide you with the necessary resources to do this. We found that it was easy to identify what services were currently offered and by whom by using a matrix service map. Ensure agreement and involvement of local pharmacies in your project from the outset. Identify the number of clinical sessions required for your service. Ensure adequate training of the nominated GPs.

Negotiating payment through Local Development Scheme arrangements - I have negotiated sessional payment at an enhanced GMS rate which is funded through the Local Development Scheme monies as part of the GMS pool. Local development schemes can attract additional GMS funds provided they are for Primary Care development which can demonstrate new services, better access and improved quality of services. Getting involved in the bid for a Local Development Scheme will ensure you become part of the negotiations at an early stage. I enlisted the help of our Medical Director of the Health Authority, the Public Health Department and the local Drug Action Team to win support for the bid.

Dr Linda Harris - The STEP Project,1st Floor Grosvenor House, 8-20 Union Street, Wakefield WF1 3AU, 01924784999 every Friday or alternatively via drlinda@doctors.org.uk. **Anybody wanting more information on how to set up a similar model of service or negotiate payment for specialist GP sessions through local development schemes is welcome to contact me**

Key points on Local Development Schemes

- Local Development Schemes and PMS, which slightly succeed them, originate from the Primary Care Act 1997.
- They provide new models for care - neither provides a source of funding.
- They basically give permission to use funding in a way it was not originally intended. Section 36 GMS money can be used to pay for the provision of what were traditionally 'non primary care services'.
- Any amount of existing or new funding intended for GMS can be used for 'extra' or 'super GMS'. There is no upper funding limit that any one scheme can attract.
- They give new flexibility for how Primary Care Groups/Trusts and Health Authorities can plan, commission and structure local services (e.g. Salaried specialised generalist led clinic supporting local primary care generalists).
- They can provide the focus for a template or service level agreement e.g. 'This is the service we want our average or special tasked GP to provide, for which we will give fee of £x and/or number of support workers/other resources.' This can provide perfect structures for ***generalist*** and ***specialised generalist*** GPs based on local or national service frameworks.

[For more information on LDS see Newsletter no.15 www.smmgp.demon.co.uk]

The Experience of Working with Drug Users as Patients
Developing a Service in Line with the Best Principles of Primary Care

I began working with drug users in primary care in 1989, when a local GP, just beginning to work with drug users, contacted the Community Drug Team to request support. It was an interesting time; shared care was embryonic, beginning to be talked about but as yet an unformed creature. Community Drug Teams had just begun to emerge as an additional form of community oriented service. This was an attempt to move away from a pure medical orientated treatment programme, towards a more community based and multi-disciplinary provision. Certainly at the time local services were heavily influenced by the local psychiatrist led Drug Dependency Unit (DDU) which operated abstinence orientated treatment programmes. The overwhelming philosophy of treatment was abstinence, with swift reductions. General Practitioners were strongly influenced by the 1984 'Orange Book' Clinical Guidelines for Managing Drug Misusers. The clinical guidelines of the day strongly supported short-term reduction programmes, being quite restrictive in the range and methods for managing drug users. Harm minimisation and risk reduction were hardly in the vocabulary of treatment services, maintenance unthinkable as an option in a large number of cases.

This type of provision seemed so incongruent to the needs of our patients. For some time I think that we, both GP and counsellor, played with the notion that we needed to fit patients to treatment programmes, and that if the treatment failed it was the fault of the user and not of the treatment. Standardised treatment seemed so incongruent in an environment where you would never know what was going to walk through the door, a young 16 year old heroin user, a mother and her family, an HIV positive long term user, with a request for injectables. Certainly our initial thinking was that treatment options seemed to be out of step, at least with the type of patients we were seeing. Support from the DDU, was limited, and there was always a fear that they took a critical view of approaches that broke away from the middle ground.

We were learning to swim, but very much without the support of specialist services. We continued despite that lack of support. Our teachers were the users. We believe that a few of the earlier patients we took on were so concerned about how we might be overloaded or used that they actually began to tell us about procedures and practice. I think we always treated these patients with respect and trust, and they responded mutually.

Certainly I know that in my 13 years in this practice we have only ever had 1 incident of risk that caused us concern. For the majority of our patients they have behaved no differently than any other set of patients, they simply have additional needs. Caring for them in primary care is an obvious place to attend to these holistic needs.

The advent of HIV infection led to a rally call to change approaches, particularly in relation to prescribing, and harm minimisation. The advent of HIV and increasingly Hepatitis C led slowly to a reduction in some of the restrictive prescribing practices we had seen as well as a validation of harm minimisation as an intervention for improved and sustained health gain. At the same time new therapeutic models for working with drug users were beginning to emerge, philosophies that validated drug users, and moved away from viewing drug users as deviant and manipulative. Integrative therapies such as Motivational Interviewing began to emerge as a humanistic approach that validated promoting choice and options for users, and giving responsibility for change back to them.

Now we work with approximately 80 drug users in primary care. Some have been with us since the beginning. We've had our successes, we have also had our failures. But for us the measure of success is the continued acknowledgement by patients that we provide a non-judgemental, empathic environment that supports them in their own change processes, and continues to provide for all their family healthcare needs.

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Brian Whitehead, Counsellor
Lonsdale Medical Centre, London, NW6 6RR

Brent now has specialist drug service that is fully integrated with primary care. Following a tendering process a new voluntary sector and local GP specialist partnership replaced the former Trust service.

Changes in FP10 Prescribing Forms Will Allow for Instalment Prescribing of Buprenorphine

Doctors in England and Wales may soon be able to write prescriptions for buprenorphine (Subutex) in daily instalments on the blue and pink FP10 forms. Whilst the legal status of buprenorphine has not changed, the FP10HP (AD) and FP10MDA prescription forms have. The pink or blue forms will be able to be used as you would for a controlled, Schedule 2 drug, such as methadone. The notes to doctors and pharmacists on these forms are to be amended to include ***'the instalment dispensing of the drug buprenorphine or any controlled drug listed in Schedule 2 of the Misuse of Drugs Regulations 1985' or*** some such similar wording.

The prescription will still needed to be written as required by the Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 1985. Computer generated prescriptions will only be permitted if you have a hand writing exemption from the Home Office. The total quantity doctors will be able to prescribe will not be able to exceed the amount sufficient for 14 days consecutive treatment. Unused spaces will need to be deleted. Weekends and Bank Holidays will need to be taken into account so that 14 days prescribing may be dispensed to cover this period. The pharmacist will record on the reverse of the form, each separate dispensing which should only be made on the day specified by the prescribing doctor.

If you require further information on buprenorphine (Subutex) please call Schering-Plough on 01707 363 697.

Dr Fixit on Volatile Substance Abuse

What is the GP's role? Since the chemical manifestations of volatile substances are for the most part reversible when abuse stops, the GPs primary function is not the treatment of the problem with medicines. GPs can help by establishing the extent of the problem and referring the patient to a more specific source of treatment.

GPs medical skills are vital in detailing the individual's history of abuse and, thereby, the kind of treatment most appropriate to the case. He or she must establish the **extent** and **duration** of abuse, **morbidity**, **antisocial behaviour**, **family** and **social problems** and follow this up with a physical and neurological examination, to ensure that no permanent damage has been done. Referral may be indicated as necessary and the GP is the best judge of the appropriate therapy. Agencies for referral may include therapists, behaviour modification programmes, hypnotists, or the community psychiatric nurse. The GP should treat a solvent abuser as any other patient and if the patient is injured or unconscious he/she should order an immediate referral to hospital. In most cases, the clinical presentation of abuse problems does not occur during acute intoxication, but the patient may later present a history of behavioural problems, family difficulties and some form of morbidity such as renal damage.

Short–term effects of solvents include and initial euphoria, followed by blurred vision, slurred speech, an uncoordinated gait and hallucinations may occur with some substances. The abuser may also fall into a coma. Sudden physical exertion while intoxicated may lead to cardiac arrythmias and can result in death. Because substances are inhaled, they are absorbed into the blood stream and reach the brain very quickly. The degree and duration of intoxication depends on the dose and duration of exposure. After the intoxication has worn off, later effects may last for days. These include headaches, stomach-aches, conjunctivitis, coughs.

Euphoria – The initial euphoria is fleeting and is followed by drunkenness similar to that of alcohol.

Hallucinations – These are mainly visual and will occur with the abuse of particular substances.

Accidents – In a study of 400 abusers, 10% had been involved in an accident or had received an associated injury, such as a fall or a burn, while intoxicated.

Hangover – A solvent hangover is likely to be less severe than that of alcohol and is unlikely to act as a deterrent.

Morbidity – Studies suggest that there is very little morbidity associated with abuse. In a survey of 788 young abusers there were no physical, haematological or biochemical abnormalities detected. The study revealed one case each of acute renal failure, encephalopathy, status epilepticus & hepatic damage. Each was thought to be caused by an idiosyncratic response to toluene.

Mortality – sudden death may occur from ventricular fibrillation, hypoxia or hypercarbia. Sudden physical exertion is a very immediate risk while intoxicated, as this may release endogenous adrenaline, which excites the myocardial fibres, leading to ventricular fibrillation. Volatile substance abuse is unique among drug problems in that the most common complication to bring the misuser to notice, is sudden death. In 1997, 37% of deaths were attributed to first-time experimentation.

Associated causes of death – Deaths have occurred through inhalation of vomit, multiple injuries sustained in accidents while intoxicated and by the toxic effects of the substance.

Dependence and addiction – A tolerance to substances may develop, but it is rare to have a psychological dependence or craving for solvents, and physical withdrawal symptoms have been found in only a few isolated cases.

Other effects to be aware of are changes in sleep patterns, changes in appetite, changes in drinking patterns, changes in behaviour such as tiredness, irritability, aggressiveness and school performance.

Child specific risk - Volatile chemicals are absorbed into the body via the large surface area of the lungs. Lipophilic solvents are attracted to fatty tissue areas, particularly in the brain, making children, who have large amounts of fatty tissues present in their bodies, particularly susceptible to damage. Most substances are exhaled in an unchanged form but some are metabolised and excreted via the kidneys.

Treatment - ***In many cases early intervention may be enough to prevent the development of a long-term problem.*** Where a habit is already active the 'sniffer' may receive treatment from various sources including social and youth services, counselling agencies and family or group therapy. The aim of all treatment is to develop the social and emotional skills to deal with the personal problems, which may be at the root of the habit. In many instances the individual is encouraged to develop reading or creative skills, or improved recreational facilities may be made available to them. With chronic abusers, more specialised help may be necessary and it is the role of the GP to separate chronic abusers from other categories by referring cases to the most appropriate agency, and offering support for the family.

Adapted from the Re-solv GP Fact Sheet. Re-solv on 01785 817885 or www.re-solv.org

Resolve is launching a free volatile substance abuse training facility off its web site.

Dr Fixit on pregnancy and prescribing methadone

Problem: "I have a patient who is an intravenous heroin user for whom I am prescribing methadone. A pregnancy test has confirmed that she is pregnant, in her sixth week. I am unsure whether I can still safely prescribe for her, or if I should begin a reduction. Also, are there any special arrangements I should be making around her health and social care needs?"

Answer: *Supplied by Simon Morton and Chris Ford*

All pregnant women, whether they use substances or not, have mixed feelings about a forthcoming child. We should always remember they are pregnant first and may have additional problems such as drug or alcohol use. Women may also have additional problems such as housing, financial and health. Remember the management of the woman and baby is an obstetric and paediatric problem rather than a moral issue. We need to be open and not judgemental when looking after women who use heroin. It is important to think about harm reduction in pregnancy and prescribe only if the benefit to the mother is thought greater than the risk to the foetus. The aim is to provide the minimum amount of opiates possible to help reduce eventual withdrawals in the baby, but a dose that the woman can tolerate and remain stable. There is no conclusive evidence that there is long-term organic (physical or brain development) damage to babies of women who use heroin or methadone during pregnancy.

Whilst many women will want to give up drugs when pregnant, others will find it difficult to stop. The main direct effect of opiate/opioid use in pregnancy appears to be babies experiencing withdrawal symptoms after birth. Low birth weight and 'small for dates' can occur but they may be related to poor

housing, bad nutrition and cigarettes rather than opiate use per say. Withdrawals in the baby do not correlate directly to the amount the woman is using, and withdrawals from heroin are easier for the baby than from methadone.

With the example given of the woman in her sixth week, it is a promising opportunity for GP intervention because know that outcomes are better if antenatal care is started early. We suggest that an assessment is undertaken to find out what she wants and proceed from there. If she wants to be prescribed, we would suggest stabilising her on the lowest dose possible of methadone and then reducing as often and at any stage in the pregnancy that she requests. All care should always be woman directed not doctor directed (the only exceptions to this are alcohol and crack with which we would try to aim the patient towards abstinence as soon as possible). Low or medium maintenance may be the best option. It is important to work with a multi-disciplinary team and recognise each other's roles. Some areas have specialist midwifes or drug workers, but many do not. It is best to check out your local arrangements and ask for help if you need it.

Next Newsletter

Dr Fixit's Tips on Opiate Detox

Practical tips on aims and process, using dyhydrocodeine, lofexedine, buprenorphine and methadone, additional therapies to support detoxification, and aftercare

Contributions welcome on this topic

The UK Harm Reduction Alliance (UKHRA)

UKHRA was launched last year (see SMMGP18), in response to concern about the erosion of harm reduction in the UK; a concern that drug policy is becoming too focused on crime reduction. The Alliance's aim is to promote harm reduction responses to drug use. Harm reduction is a philosophical and practical approach to substance use and related problems. It prioritises the reduction of harm to the individual, the community and wider society, above the desire to stop people taking any particular substance. UKHRA is a strengthening alliance between drug users, health workers, criminal justice workers, and others, which strives to place the health of the individual and public health above the need to reduce crime.

If you would like to join the discussion visit the web site at www.ukhra.org and you can join the UKHRA discussion group there or if you prefer email to Jon at jon@ukhra.org Enclosed with the newsletter is a flyer about the forthcoming conference in May 17-18th 2001 in Blackpool.

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What do you think? Contributions please! Join the mailing list. ***We look forward to hearing from you.***

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